

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024164

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

768

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED AUG 7 1961

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph, Missouri</b>		Length of stay in 1b <b>45 Years</b>	c. CITY OR TOWN <b>St. Joseph, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>719 South 9th Street</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>719 South 9th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>F.</b> Last <b>MOORE</b>			4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1878</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Dekalb County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Calvin C. Moore</b>		13b. MOTHER'S MAIDEN NAME <b>Serena Thornton</b>		14. NAME OF HUSBAND OR WIFE <b>Never Married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Brother</b> Address <b>Mo</b> <b>Mr. W. J. Moore 1110 N 18th St. St. Joe.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		<b>1 week</b>
DUE TO (b) <b>Generalized Arteriosclerosis</b>		<b>Illn.</b>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>7/19/61</b> to <b>7/29/61</b> and last saw her <b>XXX</b> alive on <b>7/27/61</b> Death occurred at <b>3:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <b>D.E. Skelmar M.D.</b> (Degree or title)	22b. ADDRESS <b>Social Welfare Board, Patee Hall 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>7/31/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 31, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Thornton Cemetery</b>
23d. LOCATION (City, town, or county) <b>Clarksdale, Missouri</b>		23e. REGISTRAR'S SIGNATURE <b>Mrs. Clara Goodell</b>
24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc. St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug 2 1961</b>

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF **D.E. Skelmar, M.D.** MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Eric J. Cheney*

Licensed Embalmer No. 4679

P. O. Address 37 Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.